

Patient Acknowledgement of Financial Responsibility



Priority Health

1231 East Beltline NE
Grand Rapids, MI 49525

I hereby authorize: _____
Print Physician's Name

of: _____
City and State

to perform the following medical service(s):

Description of Service

on: _____
Date of Service

Name of Primary Care Physician at time of service: _____

For all products (except Medicare*):

I understand this service(s) has not been authorized and I will be responsible for payment.

I have contacted my Primary Care Provider (PCP) to obtain an authorization for this service. I understand that if my PCP or the health plan deny my request, I will be responsible for payment.

For non-covered services, all products (except Medicare*):

I understand this service(s) may not be covered by my health care benefits plan, and I will be responsible for payment.

Member Signature

Date

Note: This form must be completed and signed at every visit.

* For Medicare members, please use the form "Notice of Medicare Non-Coverage".